

State of West Virginia Credentialing Form

Please complete each section thoroughly.
Attach additional sheets where necessary.
(Indicate clearly the practitioner name and section on each attachment)
Type or print clearly in black ink.
Sign and date the application.

Provider's Name	Date
Social Security Number	Date of Birth
Credentialing Entity Name	

**YOU MUST INCLUDE THE FOLLOWING WITH THIS
COMPLETED APPLICATION**
(Use this checklist as a guide)

- ☐ Copy of current State License(s)
- ☐ Copy of current DEA Registration (if applicable)
- ☐ Copy of current State Controlled Dangerous Substance (CDS) Certificate (if applicable)
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and provider's name
- ☐ Copy of Board Certification Certificate(s) (if applicable), or other National Certification Certificates
- ☐ Copy of certificate(s) or letter(s) certifying formal post-graduate training
- ☐ Copy of Curriculum Vitae/Resume (Include work history)
(Not accepted as a substitute for completion of application.)
- ☐ Copy of ECFMG Certificate (if applicable)
- ☐ Copy of W-9 for verification of each tax identification number used (required for payers only)
- ☐ Copy of Visa or work permit (if not a U.S. citizen)
- ☐ Copies of CME/CEU session certificates (if required by Credentialing Entity)
- ☐ Signature requirements per each entity

CREDENTIALING ENTITIES MAY SUPPLEMENT THIS CHECKLIST OF REQUIRED ITEMS AS NEEDED TO MEET CREDENTIALING REQUIREMENTS.

State of West Virginia

Credentialing Form

Responses must be legible. Any response, which cannot be completed in the space provided, may be included on supplementary sheets of paper and attached. **DO NOT LEAVE ANY FIELDS BLANK.** If an item is not applicable, indicate N/A. Please note you will be held responsible for all information or omissions in this application, regardless of whether such statements were prepared by you, an employee, agent or representative. For time gaps greater than three (3) months provide information in Section 11. After completion of the application, you may photocopy and then submit with a signed attestation to each entity to which you wish to apply.

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

1. Applicant Information				
Last Name (as shown on state license)	First Name	Middle Name	Maiden Name	Suffix (e.g., Jr., Sr., etc.)
Degree (e.g., MD, DO, DDS, DPM, PA-C, RN)		Gender	Birth Date	Birthplace
		Male <input type="checkbox"/> Female <input type="checkbox"/>		
Other Name(s) Also Known By				
Name(s)	Name:		Name:	
Date Name Used	From:	To:	From:	To:
Area(s) of Specialty (please be specific and list any primary focus)				
Specialty:		Sub-specialty:		
Citizenship				
Are you a US Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Please provide the following information if you are not a US Citizen:	If no, what is your citizenship?			
	If no, what is status of your Visa?			
	If no, do you hold a permanent work permit?			
	Type of Visa:		Expiration of Visa:	
Social Security #	National Provider ID # (if available)	ECFMG # (if applicable, attach copy)		ECFMG Certificate Date
Current Home Address		City	State	Zip Code
Home Telephone		Is this # unlisted?	Home Fax	
() -		<input type="checkbox"/> Yes <input type="checkbox"/> No	() -	
Language(s) Spoken (other than English)				

2. Office Practice Information																				
If you have more than one office site or more than one billing address or entity, please make a photocopy of this section before completing it and provide information for each site or billing entity (i.e., multiple tax identifiers), as needed. Indicate below whether the office is the primary or an additional site. (NOTE: Only one primary site should be designated.)																				
<input type="checkbox"/> Primary Office Site # 1				<input type="checkbox"/> Additional Office Site #																
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 5px;">Group/Practice Name</td> <td colspan="6" style="height: 20px;"></td> </tr> <tr> <td style="padding: 5px;">Type of Practice</td> <td colspan="3" style="padding: 5px;"> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Group <input type="checkbox"/> Corporation </td> <td colspan="3" style="padding: 5px;"> <input type="checkbox"/> Hospital Based <input type="checkbox"/> Teaching or Research <input type="checkbox"/> Other (specify): </td> </tr> </table>							Group/Practice Name							Type of Practice	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Group <input type="checkbox"/> Corporation			<input type="checkbox"/> Hospital Based <input type="checkbox"/> Teaching or Research <input type="checkbox"/> Other (specify):		
Group/Practice Name																				
Type of Practice	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Group <input type="checkbox"/> Corporation			<input type="checkbox"/> Hospital Based <input type="checkbox"/> Teaching or Research <input type="checkbox"/> Other (specify):																
Address (Building, Street, Suite #)				City																
State				Zip Code		County														
Telephone Number		Fax Number		Answering Service/After-Hours Number																
() -		() -		() -																
Alternate Telephone Number		Cell Phone Number		Beeper/Pager Number																
() -		() -		() -																
E-Mail Address				Long Range Beeper Number																
				() -																
Medicare Number		UPIN Number		Medicaid Number																
Are you currently accepting new patients?				Have you closed your practice to any plans or programs?																
<input type="checkbox"/> Yes <input type="checkbox"/> By referral only <input type="checkbox"/> No <input type="checkbox"/> NA				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If Yes, please list:																
Handicap Accessible?				Public Transit Available?																
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA																
Does the office have other services available for disabled? (TTY, ASI, Mental/physical impairments, etc.)				If yes, list below what services are available																
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA																				
Office Manager's Name				Nurse Manager's Name																
<input type="checkbox"/> NA				<input type="checkbox"/> NA																
Office Hours																				
<input type="checkbox"/> Check if not applicable <input type="checkbox"/> Check if practitioner is not available to see patient during hours indicated																				
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday														
AM	AM	AM	AM	AM	AM	AM														
PM	PM	PM	PM	PM	PM	PM														
Services Provided																				
(Please check below if these services are available)																				
<input type="checkbox"/> Lab Services		<input type="checkbox"/> On-Site		Reference Lab Name:		CLIA Number and Type of Certification:														
<input type="checkbox"/> Radiology Services		<input type="checkbox"/> EKG		<input type="checkbox"/> Sigmoidoscopy		<input type="checkbox"/> Audiology Services <input type="checkbox"/> Treadmill														
<input type="checkbox"/> Other (Please list):																				
<input type="checkbox"/> List any special diagnostic or treatment procedures performed in your office:																				

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Patient Population			
Do you limit the age of patients you treat?		If yes, what ages do you treat?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		Minimum:	Maximum:
Remittance/Billing Information (NOTE: Must match box 33 on HCFA/CMS 1500)			
Are all services payable to one practice or group name/address?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Group/Practice Name (Check Payable To):			
Address (Building, Street, Suite #)	City	State	Zip Code
Billing Office Phone Number		Billing Manager's Name	
() -			
Tax ID Number (must match W-9)		Name affiliated with Tax ID Number (must match W-9)	
Business Interests			
Do you or your business entity own, operate, have an interest in, or participate in any medical enterprise or business?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details on separate sheet.	
Do you have a financial relationship with a hospital, clinical lab, nursing home, pharmacy, radiology lab, emergency room, or any other medical related organization?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details on separate sheet.	
Practice Classification			
<input type="checkbox"/> Primary Care Physician (Family Practitioners, Internists, or Pediatricians who deliver primary health care services) <input type="checkbox"/> Specialist Physician (Physicians other than primary care physicians in their designated clinical practice) <input type="checkbox"/> Allied Health Professional (Licensed, certified, or registered non-physician providers of direct patient care services) <input type="checkbox"/> Dual Role (Serve as both a Primary Care Physician as well as a Specialist)			
Directory Listing			
Should this office be listed in the directory?		Should this office receive correspondence?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please indicate, in preference order, how you wish to be listed in the directory.			
Primary Specialty:		Secondary Specialty:	
After-Hours Coverage			
Do you provide 24-hour coverage?		Describe Coverage	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA			
Do you have an answering service/machine?		Is your answering service/machine available at all times when you are not in the office?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
List below other after-hours arrangements or special instructions to patients for after-hours care needs:			

Back-up Coverage (Please list the name, specialty, and phone number of partner(s) or associate(s) or physician(s) covering your practice in your absence.)			
Name	Specialty	Partner, Associate, Or Covering	Phone Number
			() -
			() -
			() -
			() -

Admitting Service	
Do you admit patients to the hospital under your own service?	If no, to whom do you admit?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	

Practitioner Extenders Please check any of the following practitioner extender types and list individual names who you either employ or utilize for direct patient care.	
<input type="checkbox"/> Physician's Assistant:	<input type="checkbox"/> Nurse Practitioner:
<input type="checkbox"/> Nurse Midwife:	<input type="checkbox"/> Other (specify):

Workers' Compensation Information	
Do you accept Workers' Compensation Patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide the following information:	<div style="margin-top: 10px;"> a. Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div style="margin-top: 10px;"> b. Modified or alternative duty is actively evaluated for each Workers' Compensation claimant. <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div style="margin-top: 10px;"> c. Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible. <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div style="margin-top: 10px;"> d. Staff are available and willing to provide compensation representatives information regarding a claimant's care. <input type="checkbox"/> Yes <input type="checkbox"/> No </div>

3. Medical/Professional Education:			
(Attach copy of diploma. If international graduate, submit ECFMG Certificate.) If additional space is needed, please photocopy this page and attach. All time gaps greater than three (3) months must be accounted for in Section 11.			
Name of School	Degree Received	Dates of Attendance (List Mo/Yr)	
		From:	To:
Street Address	Phone # (if known)	Fax # (if known)	Graduation Date
	() -	() -	
City	State	Country	Zip Code
Name of School	Degree Received	Dates of Attendance (List Mo/Yr)	
		From:	To:
Street Address	Telephone # (if known)	Fax # (if known)	Graduation Date
	() -	() -	
City	State	Country	Zip Code
4. Professional Training - Internship/Residency/Fellowship/Preceptorship/Other			
List all, completed or not. (Attach copies of all program certificates.) All time gaps greater than three (3) months must be accounted for in Section 11.			
Training Institution		Program	
		<input type="checkbox"/> Internship <input type="checkbox"/> Fellowship <input type="checkbox"/> Other: <input type="checkbox"/> Residency <input type="checkbox"/> Preceptorship	
Street Address		City	
State	Country		Zip Code
Telephone # (if known)		Fax # (if known)	
() -		() -	
Type of Training/Specialty	Dates of Training (Mo/Yr)	Was program successfully completed?	
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:	
Your Program Director's Name		Current Program Director's Name (if known)	
Training Institution		Program	
		<input type="checkbox"/> Internship <input type="checkbox"/> Fellowship <input type="checkbox"/> Other: <input type="checkbox"/> Residency <input type="checkbox"/> Preceptorship	
Street Address		City	
State	Country		Zip Code
Telephone # (if known)		Fax # (if known)	
() -		() -	
Type of Training/Specialty	Dates of Training (Mo/Yr)	Was program successfully completed?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:	
Your Program Director's Name		Current Program Director's Name (if known)	

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Training Institution				Program		
				<input type="checkbox"/> Internship	<input type="checkbox"/> Fellowship	<input type="checkbox"/> Other:
				<input type="checkbox"/> Residency	<input type="checkbox"/> Preceptorship	
Street Address				City		
State		Country		Zip Code		
Telephone # (if known)				Fax # (if known)		
() -				() -		
Type of Training/Specialty		Dates of Training (Mo/Yr)		Was program successfully completed?		
				<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:		
Your Program Director's Name				Current Program Director's Name (if known)		

Training Institution				Program		
				<input type="checkbox"/> Internship	<input type="checkbox"/> Fellowship	<input type="checkbox"/> Other:
				<input type="checkbox"/> Residency	<input type="checkbox"/> Preceptorship	
Street Address				City		
State		Country		Zip Code		
Telephone # (if known)				Fax # (if known)		
() -				() -		
Type of Training/Specialty		Dates of Training (Mo/Yr)		Was program successfully completed?		
				<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:		
Your Program Director's Name				Current Program Director's Name (if known)		

5. State License(s): List all current and past professional licenses (Submit copy of current licenses)

State	License #	Issue Date	Expiration Date	Status (Please check)	Is/was license restricted?	Reason License is/was Inactive or Restricted
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Does the scope of your practice require the supervision of another practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please list name of each supervising practitioner:	Practitioner Name:

6. Certifications/Registrations			
<input type="checkbox"/> Check here if entire section is not applicable to applicant.			
Federal DEA Certificate <input type="checkbox"/> Not applicable (Submit copy of current DEA Certificate)			
Certificate #	Expiration Date	Unlimited?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:	
State DEA or CDS Certificate(s) <input type="checkbox"/> Not applicable (Submit copy of current State Controlled Dangerous Substance Certificates, if applicable)			
Certificate #	Expiration Date	Unlimited?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:	
Other Certificate(s)/Formal Training (Please check below if currently certified. Submit copy(s))			
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Basic Life Support (BLS) <input type="checkbox"/> Advanced Cardiac Life Support (ACLS) <input type="checkbox"/> Pediatric Advanced Life Support (PALS) <input type="checkbox"/> Advanced Trauma Life Support (ATLS) <input type="checkbox"/> Neonatal Advanced Life Support (NALS) </div> <div style="width: 50%;"> <input type="checkbox"/> Anesthesia Permit <input type="checkbox"/> Health Care Provider (Core C) <input type="checkbox"/> Neonatal Resuscitation Program (NRP) <input type="checkbox"/> Therapeutics Classification Number (Optometrists only) <input type="checkbox"/> Other (please list below or on a separate sheet and include descriptions): </div> </div>			
7. Specialty Board Certification: Submit copies of board certifications and/or qualification confirmation letter.			
<input type="checkbox"/> Check here if entire section is not applicable to applicant.			
Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list below)			
Certifying Board Name & Specialty	Initial Certification Date	Most Recent Recertification Date	Next Expiration Date
If not certified, are you qualified to sit for the examination?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If not certified, please indicate your status in the certifying process:	<input type="checkbox"/> Failed to pass specialty board examination <ul style="list-style-type: none"> How many times have you taken the exam but failed to pass? _____ Last date(s) exam was taken: _____ <input type="checkbox"/> Date(s) board examination was taken/retaken and date board exam is scheduled, if applicable: <ul style="list-style-type: none"> Date(s) taken/retaken: _____ Date scheduled, if applicable: _____ <input type="checkbox"/> Not eligible to take specialty boards <input type="checkbox"/> Not planning to take specialty boards <input type="checkbox"/> Admissible with exam pending		

8. Professional Peer References

Please list three (3) professional peer references who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others, and who will provide specific written comments on these and other relevant matters upon request. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you. These individuals must have acquired the requisite knowledge through observation of your professional practice over a reasonable period of time. At least one reference must be from the same specialty area, not formerly, currently or about to become associated with you in practice. At least one must be from an individual who has had organizational responsibility in a medical setting (e.g., Department Chair, Medical Director). If your training was completed within the past three (3) years, you may list your Program Director(s) as a professional reference. If you have been out of training for more than three (3) years, it is important to name individuals who are more currently familiar with your professional practice. The individuals should not be related to you by family or financial association.

Reference Name 1		Title	
Street Address	City	State	Zip
Telephone Number	Fax Number (if known)		
() -	() -		
Relationship: (instructor, department chair, chief of staff, colleague, etc.)			
Reference Name 2		Title	
Street Address	City	State	Zip
Telephone Number	Fax Number (if known)		
() -	() -		
Relationship: (instructor, department chair, chief of staff, colleague, etc.)			
Reference Name 3		Title	
Street Address	City	State	Zip
Telephone Number	Fax Number (if known)		
() -	() -		
Relationship: (instructor, department chair, chief of staff, colleague, etc.)			

9. Hospital/Facility Affiliations (list current affiliation first)			
<input type="checkbox"/> Check here if entire section is not applicable to applicant.			
List ALL health care facilities at which you currently have, or have had, privileges. Explain gaps greater than three (3) months in Section 11.			
Name of Current Primary Hospital Affiliation		Type of Affiliation	
Street Address		City	State
			Zip
Department/Service		Department Chair's Name	
Staff Status		# Admits/Month	Percent of time spent at facility
Restricted?		Dates of Affiliation (Mo/Yr)	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		From: To:	
Reason for leaving, if applicable			
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation	
Street Address		City	State
			Zip
Department/Service		Department Chair's Name	
Staff Status		# Admits/Month	Percent of time spent at facility
Restricted?		Dates of Affiliation (Mo/Yr)	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		From: To:	
Reason for leaving, if applicable			
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation	
Street Address		City	State
			Zip
Department/Service		Department Chair's Name	
Staff Status		# Admits/Month	Percent of time spent at facility
Restricted?		Dates of Affiliation (Mo/Yr)	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		From: To:	
Reason for leaving, if applicable			

9. Additional Affiliations:			
(Photocopy this page for additional affiliations)			
Name of Affiliation/Hospital/Healthcare Entity	Type of Affiliation		
Street Address	City	State	Zip
Department/Service	Department Chair's Name		
Staff Status	# Admits/Month	Percent of time spent at facility	
Restricted?	Dates of Affiliation (Mo/Yr)		
If yes, explain: <input type="checkbox"/> Yes <input type="checkbox"/> No	From:	To:	
Reason for leaving, if applicable			
Name of Affiliation/Hospital/Healthcare Entity	Type of Affiliation		
Street Address	City	State	Zip
Department/Service	Department Chair's Name		
Staff Status	# Admits/Month	Percent of time spent at facility	
Restricted?	Dates of Affiliation (Mo/Yr)		
If yes, explain: <input type="checkbox"/> Yes <input type="checkbox"/> No	From:	To:	
Reason for leaving, if applicable			
Name of Affiliation/Hospital/Healthcare Entity	Type of Affiliation		
Street Address	City	State	Zip
Department/Service	Department Chair's Name		
Staff Status	# Admits/Month	Percent of time spent at facility	
Restricted?	Dates of Affiliation (Mo/Yr)		
If yes, explain: <input type="checkbox"/> Yes <input type="checkbox"/> No	From:	To:	
Reason for leaving, if applicable			

10. Work History/Experience:

List in chronological order (beginning with current) all current and previous professional work history including Military Service. You must explain gaps greater than three (3) months in Section 11. (If additional space is needed, please photocopy this page and attach.)

Practice/Employer				Contact Name		
Street Address				City	State	Zip
Phone Number				Fax Number (if known)		
() -				() -		
Dates of Employment				Reason for leaving, if applicable		
From: To:						
Practice/Employer				Contact Name		
Street Address				City	State	Zip
Phone Number				Fax Number (if known)		
() -				() -		
Dates of Employment				Reason for leaving, if applicable		
From: To:						
Practice/Employer				Contact Name		
Street Address				City	State	Zip
Phone Number				Fax Number (if known)		
() -				() -		
Dates of Employment				Reason for leaving, if applicable		
From: To:						
Practice/Employer				Contact Name		
Street Address				City	State	Zip
Phone Number				Fax Number (if known)		
() -				() -		
Dates of Employment				Reason for leaving, if applicable		
From: To:						

11. Time Gaps			
Provide information for all time frames of three (3) months or more that are not covered in Medical/Professional Education, Professional Training, Hospital/Facility Affiliations, or Work History/Experience sections (such as extended travel, maternity leave, relocation, etc.).			
<input type="checkbox"/> Check here if entire section is not applicable to applicant.			
Section	Dates	Explanation	
Medical/Professional Education	From:		
	To:		
	From:		
To:			
Professional Training	From:		
	To:		
	From:		
To:			
Hospital/Facility Affiliations	From:		
	To:		
	From:		
To:			
Work History/Experience	From:		
	To:		
	From:		
To:			
12. Continuing Education Requirements			
<input type="checkbox"/> Check here if entire section is not applicable to applicant.			
A. Have you completed the continuing education hours as required by your State Licensing Board during the past two (2) years <u>OR</u> the required CME/CEU hours (if applicable) from the State licensing board in which you are currently practicing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Attach certificates (if required by Credentialing Entity) for the CME/CEU sessions you have completed in last two (2) years.			

13. Professional Associations/Organizations	
List the associations/organizations related to your profession in which you are a member. Please include dates of affiliations. Include faculty appointments.	
Professional Association/Organization	Dates of Affiliation
	From: To:
Professional Association/Organization	Dates of Affiliation
	From: To:
Professional Association/Organization	Dates of Affiliation
	From: To:
Professional Association/Organization	Dates of Affiliation
	From: To:
Professional Association/Organization	Dates of Affiliation
	From: To:

14. Professional Liability Insurance Coverage:

Submit a copy of your current professional liability insurance coverage face sheet showing coverage in your practice specialty. Please list current and previous insurance carriers for the last ten (10) years in chronological order beginning with most current. (If additional space is needed, please photocopy this page and attach.)

Current Insurance Carrier		Telephone Number		
		() -		
Address		City	State	Zip
Policy Number	Expiration Date	Amount of Coverage		If Umbrella/Excess coverage, amount of coverage
		\$ million/occurrence		\$
		\$ million/aggregate		
Years with Carrier		Type of Coverage		Do you have prior acts coverage?
		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence		<input type="checkbox"/> No <input type="checkbox"/> Yes
Second Current Insurance Carrier		Telephone Number		
		() -		
Address		City	State	Zip
Policy Number	Expiration Date	Amount of Coverage		If Umbrella/Excess coverage, amount of coverage
		\$ million/occurrence		\$
		\$ million/aggregate		
Years with Carrier		Type of Coverage		Do you have prior acts coverage?
		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence		<input type="checkbox"/> No <input type="checkbox"/> Yes
Previous Insurance Carrier		Telephone Number		
		() -		
Address		City	State	Zip
Policy Number	Expiration Date	Amount of Coverage		If Umbrella/Excess coverage, amount of coverage
		\$ million/occurrence		\$
		\$ million/aggregate		
Years with Carrier		Type of Coverage		Do you have prior acts coverage?
		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence		<input type="checkbox"/> No <input type="checkbox"/> Yes
Previous Insurance Carrier		Telephone Number		
		() -		
Address		City	State	Zip
Policy Number	Expiration Date	Amount of Coverage		If Umbrella/Excess coverage, amount of coverage
		\$ million/occurrence		\$
		\$ million/aggregate		
Years with Carrier		Type of Coverage		Do you have prior acts coverage?
		<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence		<input type="checkbox"/> No <input type="checkbox"/> Yes

15. Professional Liability Insurance Coverage Disclosure:		
<p>If the answer to any of these questions is yes, please provide a full explanation of the details of each and every matter on the attached Professional Liability Information Addendum. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, and the name and address of the attorney defending you, and all other relevant details. Include suits in which a judgment or settlement was made against a professional corporation of which you are/were a member, shareholder, or employee in any matter in which you were involved in the patient's care.</p>		
A. Has your professional liability insurance coverage ever been terminated by action of the insurance company?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
B. Have you ever been denied professional liability insurance coverage?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
C. Has any (current or previous) professional liability insurance carrier excluded any specific procedures or specific area of practice (e.g., obstetrics, surgery, etc.) from your coverage?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
D. During the time of your professional practice, have you had any professional liability claims, suits, settlements, or judgments filed against you or are any currently pending?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
E. Have any restrictions ever been placed on your professional liability insurance coverage?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
F. Have you ever practiced without professional liability coverage?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
G. Are there any incidents for which you have been contacted by an attorney regarding potential professional liability (e.g., settlement requests, writ of summons, etc.)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Professional Liability Information Addendum

(Photocopy this form for each case/action)

Please supply the following information for:

- Each professional liability action you have had taken against you, including those pending.
- Each settlement, or decision for the plaintiff that has ever occurred on your behalf.

All information is held in strict confidence and used for credentialing and recredentialing purposes only. Failure to supply sufficient details may prevent your application from being approved. In addition to completion of this form, practitioner may also submit any additional supporting documentation.

☐ Check here if entire section is not applicable to applicant.

1. Case Number	2. Carrier Name
3. Name of Plaintiff	4. Date of Incident
5. Date Filed	6. Date Closed
7. What was/is your status in the case?	8. What is the status of the case?
<input type="checkbox"/> Primary Defendant <input type="checkbox"/> Co-Defendant <input type="checkbox"/> Other, please explain:	<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Dropped <input type="checkbox"/> Pending <input type="checkbox"/> Settled Out of Court </div> <div> <input type="checkbox"/> Found for Defendant <input type="checkbox"/> Dismissed Without Payment <input type="checkbox"/> Found for Plaintiff <input type="checkbox"/> Under Appeal </div> </div>
9. Amount of Any Settlement or Award?	10. Date of any Settlement or Award

Please explain the following in detail. (If an item does not apply please check "N/A")

11. What was the alleged harm to the patient?		<input type="checkbox"/> N/A
12. What were you alleged to have done incorrectly or failed to do?		<input type="checkbox"/> N/A
13. Describe the patient's illness and related effects of the alleged harm.		<input type="checkbox"/> N/A
14. Describe any other details you believe are pertinent to the case.		<input type="checkbox"/> N/A
15. Identify any other parties named in the suit.		<input type="checkbox"/> N/A

Signature	Date

16. Practice Disclosure Information			
If the answer to any question below is yes, please provide a full explanation of the details on a separate sheet and attach.			
A. Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory agency?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
B. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
C. Have you ever been suspended, sanctioned, or otherwise restricted from participating or been the subject of an investigation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
D. Has your narcotics (DEA) registration certificate (federal or state) ever been voluntarily or involuntarily relinquished, limited, suspended, not renewed, placed on probation, revoked, or challenged?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> NA
E. Have you ever been convicted of or plead no contest to any criminal (felony or misdemeanor) charges including a drug or alcohol-related offense or motor vehicle offenses, but not including minor traffic or parking violations? Are any such proceedings currently pending?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> NA
G. Have you ever been discharged or asked to resign from any position for any reason?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
H. Have you ever resigned or retired from a position after being notified you would be disciplined or after questions about your clinical competence were raised?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
I. Have you ever been refused membership on the medical or allied health staff of any hospital or institution or been denied advancement in staff status?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> NA
J. Has your employment, medical staff status, appointment, reappointment, or clinical privileges, or scope of practice ever been voluntarily or involuntarily suspended, restricted, reduced, revoked, denied, relinquished, not been renewed or subjected to probationary conditions or limited at any hospital, managed care organization or other health care facility?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
K. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation, or otherwise sanctioned by any health care organization, including but not limited to, hospitals, HMOs, PPOs, IPAs, PHOs, professional associations or societies, professional standards review organization or peer review organizations, or any other health care facilities, based on professional competence?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
L. Have you ever withdrawn your application for appointment, reappointment or request for clinical privileges or resigned from the medical or allied health staff of a hospital, managed care organization, or other health care facility while under investigation or before a decision about your appointment or reappointment or clinical privileges was rendered by the governing board of any hospital, managed care organization or any other health care facility?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
M. Have you ever been allowed to resign your position or voluntarily relinquish specific clinical privileges rather than face any charge or investigation on the part of the medical staff of a hospital, managed care organization, or other health care facility?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
N. Are there currently pending adverse actions on your employment, medical staff appointment, reappointment, clinical privileges or scope of practice at any hospital, managed care organization, or other health care facility?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

O. Has any investigation (other than normal performance improvement reviews) involving your clinical practice, competence or professional conduct ever been initiated by any hospital, managed care organization, governmental agency, other health care facility, or branch of the armed forces?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
P. Has your request for any specific clinical privileges or scope of practice ever been denied (as a result of disciplinary action) or granted with stated limitations or conditions (aside from ordinary initial probationary requirements of proctorship)? Are such proceedings currently pending?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Q. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
R. Have you had any charges of unprofessional conduct brought against you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
S. Have you had any charges of fraud brought against you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
T. Have you received any confirmed Quality Citations from a Peer Review Organization (PRO) in the last two (2) years? If you answered yes, on a separate sheet, indicate the address of the PRO that cited you, the circumstances of the citation and the number of points you were fined.	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Health Status		
<p>Note: Your application will be processed in the usual manner regardless of how you answer questions A and B. If you have answered "No" to question A or B, please explain completely on a separate sheet. If you are found to be qualified, a representative will contact you to determine what accommodations are necessary and feasible to allow you to practice safely.</p>		
A. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without a reasonable accommodation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Are you able to perform these functions without significant risk of injury to yourself or others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Do you presently have a physical or mental health condition, including alcohol or drug dependence that affects, or is reasonably likely to affect your ability to perform professional or medical staff duties appropriately? If yes, give a full explanation of the details on a separate sheet.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Do you currently take any medication that may affect either your clinical judgment or motor skills? If yes, give a full explanation of the details on a separate sheet.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Health Care Entity:

WEST VIRGINIA PRACTITIONER AUTHORIZATION AND RELEASE OF INFORMATION

By submitting this authorization and release of information form in conjunction with the West Virginia Credentialing Form (WVCF) and/or the West Virginia Practitioner Attestation, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Health Care Entity indicated on the WVCF for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and/or other qualifications.
2. I further understand and acknowledge that the Health Care Entity or designated Agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Health Care Entity as part of the verification and credentialing process.
3. I authorize all individuals, institutions, and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Health Care Entity(ies), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the requested clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.
5. I attest to the accuracy and completeness of the information provided. I understand and agree that any misstatements in or omissions from the WVCF Attestation and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.
6. I agree to exhaust all available procedures and remedies as outlined by in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Health Care Entity(ies) where I have membership and/or clinical privileges/participation.
7. I understand that completion and submission of the WVCF Attestation/Authorization and Release of Information does not automatically grant me membership or clinical privileges/participating status with the Health Care Entity(ies) indicated on the WVCF or Attestation.
8. I further acknowledge that I have read and understand the foregoing Authorization and Release of Information. A photocopy of this Authorization and Release of Information shall be as effective as the original, and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

Print Name Here: _____

Signature: _____

Date: _____

NOTE: Through above signature, I hereby affirm that contents are current and accurate as of the signature date.

Modification to the wording or format of the WVCF/Attestation/Authorization and Release of Information may invalidate an application.

Credentialing Entity may supplement additional Authorization/Release of Information through an additional release document as required by the entity.

The Entities will treat this application and any information secured in connection therewith in strict confidence in accordance with the Entities' policies and/or Medical Staff Bylaws and preserve with all reasonable safeguards the privacy of the Applicant.

ADDENDUM

VERIFICATION OF PROFESSIONAL LIABILITY

I, the undersigned, authorize my CURRENT professional liability insurance carrier,

(Enter Current Professional Liability Insurance Carrier Name)

(Enter Street Address)

(City)

(State & Zip)

to send verification of my professional liability coverage, to include dates of coverage, amounts of coverage, and any limitations in coverage, to _____

(Entity Specific)

_____ is to hereinafter be

(Entity Specific)

a Certificate Holder and is to be notified of the amount of my coverage and any future changes in my insurance status.

I will notify _____ of any

(Entity Specific)

changes in Professional Liability carriers so that another Verification of Professional Liability form can be completed.

Physician's Signature

Date

Printed Name

Policy Number

(Instructions: Please complete, sign, date and return to entity named above with your initial application.)